

Send To:
Office of the Medical Director
2502 E. University Drive
Phoenix, Arizona 85034

Maricopa Integrated Health System

Formulary Addition Request Form

Pharmacy & Therapeutics Committees

To Be Completed by Requesting Physician:

Request Date:

Drug to be added to which formulary(s): *(Check)*

☐ Hospital (mainly inpatient)

☐ Health Plan (mainly

Estimated Cost: \$

Projected use of drug/month:

Why add this drug to formulary?

What formulary drug(s) should it replace?:

Requesting Physician:

(Please Print)

Signature:

Phone#:

Generic Name:

Brand Name:

Dosage Forms Requested: *(Check)*

☐ Tablet/ Cap

☐ Liquid/ Suspension

☐ Parenteral

☐ Ointment/ Cream

☐ Suppository

☐ Other

**Please submit at least two (2) clinical articles that supports the addition of this drug to the formulary.
Do not send promotional materials.**

To Be Completed by Clinical Pharmacist:

Pharmaceutical Company:

Acquisition Cost:

Pharmacologic Classification:

Projected use of drug/month:

FDA – approved indications:

Summary of efficacy:

Summary of Pharmacology:

Summary of Toxicity:

Signature:

Date:

Phone#: